

Study number:

MEDICAL PHOTOGRAPHY FORM

A1 ID Number _____

A2 Name _____

A3 Date of Birth / /
dd/mm/yy

A4 Hospital Number _____

A5 Today's date / /

Place for Cleft identification sticker
if available

Facial photographs obtained

- | | | | | | |
|-----|---|-----|---------------------------------------|----|---------------------------------------|
| B01 | Face AP | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B02 | Face AP smiling | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B03 | Face right lateral | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B04 | Face left lateral | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B05 | Lips/ nose AP | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B06 | Lips/ nose AP (lips whistling/ blowing) | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B07 | Lips/ nose worm's eye view (WEV) | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |

Intra oral photographs obtained

- | | | | | | |
|-----|---------------------------|-----|---------------------------------------|----|---------------------------------------|
| B08 | Teeth right oblique | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B09 | Teeth AP | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B10 | Teeth left oblique | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B11 | Palate (hard) | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B12 | Teeth upper arch (mirror) | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |
| B13 | Teeth overjet | Yes | <input type="checkbox"/> ₁ | No | <input type="checkbox"/> ₂ |

Thank you for filling this in – please state your

C1 Name: _____

C2 Designation: _____

C3 Email: _____

C4 Contact number: _____

C5 Any additional information that you think would be helpful is most welcome.

Study number:

Facial views Magnification ratio 1:8



B01

B02

B03

B04

Lip/ nose views Magnification ratio 1:4



B05

B06

B07

Intra-oral views Magnification ratio 1:2



B08

B09

B10



B11

B12

B13

Contact for medical photography:

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